

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0024356</u></p> <p>Facility Name: <u>Lee Manor</u></p> <p>Address: <u>1301 Lee Street</u> <u>Des Plaines</u> <u>60018</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 635-4000</u> Fax # <u>(847) 827-5796</u></p> <p>IDPA ID Number: <u>362998136001</u></p> <p>Date of Initial License for Current Owners: <u>6/21/79</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2005</u> to <u>12/31/2005</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 30%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p style="text-align: center;">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lee Manor# 0024356 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 12/13/2005

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	282	Skilled (SNF)	262	102,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	282	TOTALS	262	102,550	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,349		6,597	7,946	8
9	SNF/PED					9
10	ICF	43,993	9,046	2,402	55,441	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,342	9,046	8,999	63,387	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.81%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 6/29/79

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 46 and days of care provided 6,597Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

Lee Manor
Provider #: 0024356
1/1/2005 to 12/31/2005

Schedule 2A

Line 7 - Licensed Bed Days

	Beds	Days	Total
Jan 1 - Dec 12	282	346	97,572
Dec 13 - Dec 31	262	19	4,978
		365	102,550

Beds available

SEE ACCOUNTANTS' COMPILATION REPORT

PORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	343,063	43,035	11,856	397,954		397,954		397,954		1
2	Food Purchase		320,166		320,166		320,166	(9,203)	310,963		2
3	Housekeeping	295,495	30,066		325,561		325,561		325,561		3
4	Laundry	58,866	21,601		80,467		80,467	(8,322)	72,145		4
5	Heat and Other Utilities			209,889	209,889		209,889		209,889		5
6	Maintenance	42,786	6,974	90,424	140,184		140,184		140,184		6
7	Other (specify):*										7
8	TOTAL General Services	740,210	421,842	312,169	1,474,221		1,474,221	(17,525)	1,456,696		8
B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,324,247	408,609	1,320	3,734,176		3,734,176		3,734,176		10
10a	Therapy	189,657		67,042	256,699		256,699		256,699		10a
11	Activities	126,003	24,681	2,144	152,828		152,828		152,828		11
12	Social Services	76,086		3,200	79,286		79,286		79,286		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,715,993	433,290	97,706	4,246,989		4,246,989		4,246,989		16
C. General Administration											
17	Administrative	88,032		93,333	181,365		181,365		181,365		17
18	Directors Fees										18
19	Professional Services			122,923	122,923		122,923	(46,051)	76,872		19
20	Dues, Fees, Subscriptions & Promotion			21,349	21,349		21,349	(29)	21,320		20
21	Clerical & General Office Expense	396,606	48,388	51,700	496,694		496,694	(5,152)	491,542		21
22	Employee Benefits & Payroll Taxes			730,881	730,881		730,881	6,573	737,454		22
23	Inservice Training & Education			17,487	17,487		17,487		17,487		23
24	Travel and Seminars			6,273	6,273		6,273		6,273		24
25	Other Admin. Staff Transportation			7,554	7,554		7,554		7,554		25
26	Insurance-Prop.Liab.Malpractice			192,414	192,414		192,414		192,414		26
27	Other (specify):*										27
28	TOTAL General Administration	484,638	48,388	1,243,914	1,776,940		1,776,940	(44,659)	1,732,281		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,940,841	903,520	1,653,789	7,498,150		7,498,150	(62,184)	7,435,966		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lee Manor

#0024356

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			70,994	70,994		70,994	163,362	234,356			30
31	Amortization of Pre-Op. & Org											31
32	Interest			62,195	62,195		62,195	351,051	413,246			32
33	Real Estate Taxes			3,000	3,000		3,000	439,571	442,571			33
34	Rent-Facility & Grounds			1,343,880	1,343,880		1,343,880	(1,343,880)				34
35	Rent-Equipment & Vehicle			11,445	11,445		11,445		11,445			35
36	Other (specify): ³											36
37	TOTAL Ownership			1,491,514	1,491,514		1,491,514	(389,896)	1,101,618			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			785	785		785		785			38
39	Ancillary Service Center:		245,364	40,100	285,464		285,464		285,464			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			153,825	153,825		153,825		153,825			42
43	Other (specify): ³ Nonallowable Cost			140,361	140,361		140,361	(140,361)				43
44	TOTAL Special Cost Centers		245,364	335,071	580,435		580,435	(140,361)	440,074			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,940,841	1,148,884	3,480,374	9,570,099		9,570,099	(592,441)	8,977,658			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Program				3
4 Non-Patient Meals	(2,630)	2		4
5 Telephone, TV & Radio in Resident Room				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patient				7
8 Laundry for Non-Patients	(8,322)	4		8
9 Non-Straightline Depreciation	(27,511)	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refund				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(2,031)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transaction				15
16 Personal Expenses (Including Transportation				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(73)	43		18
19 Entertainment	(4,041)	43		19
20 Contributions	(5,207)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer	(34,003)	19		22
23 Malpractice Insurance for Individual				23
24 Bad Debt	(60,000)	43		24
25 Fund Raising, Advertising and Promotiona	(60,303)	43		25
26 Income Taxes and Illinois Personal				26
Property Replacement Tax	(1,420)	43		26
27 CNA Training for Non-Employee				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(33,666)	var		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (239,207)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule	\$		31
32 Donated Goods-Attach Schedule			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(353,234)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (353,234)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (592,441)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport		x	\$		38
39					39
40 Gift and Coffee Shop		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lee Manor

Provider #: 0024356

1/1/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

Non-allowable expenses	Amount	Reference
X-Ray	(8,426)	43
Trust fees	(280)	43
Miscellaneous income offset	(5,932)	21
Non-allowable interest on shareholder loan	(18,443)	32
Chamber of Commerce	(585)	20
Total	<u>(33,666)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Gamma Trusts (7)	45	See Schedule 6A		Seneca Building	Des Plaines	Lessor
Dorothy Vangel QSS Trust	33.75			Limited Partnership		
Descendants' GST Trusts (5)	11.25					
Chester Plodzien	10					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	21	Bank Charges	\$	Seneca Building Limited Partnership	100.00%	\$ 780	\$ 780	1
2	V	30	Depreciation		Seneca Building Limited Partnership	100.00%	190,873	190,873	2
3	V	32	Interest		Seneca Building Limited Partnership	100.00%	369,494	369,494	3
4	V	33	Real estate taxes		Seneca Building Limited Partnership	100.00%	428,079	428,079	4
5	V	34	Rent - Facility & Grounds	1,343,880	Seneca Building Limited Partnership	100.00%		(1,343,880)	5
6	V	43	Replacement Tax		Seneca Building Limited Partnership	100.00%	1,420	1,420	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,343,880			\$ 990,646	\$ * (353,234)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence

Provider #0024356

12/31/2005

Schedule 6A

Page 6, Schedule VII, Part A: Related Nursing Home

Name	City
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park
Butterfield Health Care II, Inc. - Meadowbrook Manor	Naperville
Butterfield Health Care, Inc. - Meadowbrook Manor	Bolingbrook

See Accountants' Compilation Report

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Chester Plodzien	Owner/Officer	Administrative	10.00	None	8	20.00	Mgmt. Fee	\$ 9,333	L17,C3	1
2	Dorothy Vangel	Administrative	Administrative	25.00***	None	8	20.00	Mgmt. Fee	42,000	L17,C3	2
3	Jason Samatas	Administrative	Administrative	6.4285**	157,772	4	8.00	Mgmt. Fee	42,000	L17,C3	3
4	Sean Dimas	Administrative	Administrative	6.67*	None	40	100.00	Salary	42,579	L21,C1	4
5	Emy Plodzien	DON	Administrative	0.00	None	40	100.00	Salary	47,076	L10,C1	5
6	Chester Plodzien	Owner/Officer	Administrative	10.00	None	8	20.00	Salary	4,500	L17, C1	6
7					See Schedule 7A						7
8											8
9		*Ownership of Lee Manor held by Decendants S Corp Trust F/B/O Sean William Dimas									9
10		**Ownership of Lee Manor held by George Samatas 1998 Gamma Trust for Jason U/A/D 11/25/98									10
11			***Ownership through attribution								11
12											12
13								TOTAL	\$ 187,488		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence
Provider #0024356
12/31/2005

Schedule 7A

Compensation Received From Other Nursing Homes

Name of Facility	Jason Samatas
Lexington Health Care Center of Bloomingdale, Inc.	13,328
Lexington Health Care Center of Chicago Ridge, Inc.	17,357
Lexington Health Care Center of Elmhurst, Inc.	11,623
Lexington Health Care Center of LaGrange, Inc.	8,839
Lexington Health Care Center of Lake Zurich, Inc.	16,505
Lexington Health Care Center of Lombard, Inc.	17,357
Lexington Health Care Center of Orland Park, Inc.	20,923
Lexington Health Care Center of Schaumburg, Inc.	17,357
Lexington Health Care Center of Streamwood, Inc.	17,357
Lexington Health Care Center of Wheeling, Inc.	17,126
	<u>157,772</u>

See Accountants' Compilation Report

Facility Name & ID Number Lee Manor# 0024356

Report Period Beginning:

1/1/2005Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9				N/A					9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank One, NA		X	Mortgage	\$40,806.00	8/15/03	\$ 6,500,000	\$ 6,192,152	8/15/10	0.0575	\$ 365,476	1	
2												2	
3								Amortization of mortgage costs			6,876	3	
4												4	
5												5	
	Working Capital												
6	Bank One, NA		X	Line of Credit	Interest only	8/15/04	2,000,000	895,671	8/15/05	Variable	43,752	6	
7	Shareholder loan	X			Interest only		307,000	287,000	Demand	0.0400	18,443	7	
8												8	
9	TOTAL Facility Related				\$40,806.00		\$ 8,807,000	\$ 7,374,823				\$ 434,547	9
	B. Non-Facility Related*												
10												10	
11								Interest Income offset			(2,858)	11	
12								Non-related interest			(18,443)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$				\$ (21,301)	14
15	TOTALS (line 9+line14)						\$ 8,807,000	\$ 7,374,823				\$ 413,246	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lee Manor**# **0024356** Report Period Beginning: **1/1/2005** Ending: **12/31/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2004 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report	\$	400,315	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2004	\$	431,738	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	31,423	3																			
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	397,576	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	14,492	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			\$	(920)	6																			
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	(920)	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	442,571	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2000	384,758	8	<table border="1"> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2001	387,758	9																					
	2002	397,562	10																					
	2003	408,894	11																					
	2004	431,738	12																					
2004 Taxes = \$ 431,738																								
2005 Accrual - Estimated Reduction																								

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

FACILITY NAME	Lee Manor	COUNTY	Cook
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FACILITY IDPH LICENSE NUMBER 0024356

CONTACT PERSON REGARDING THIS REPORT James Reth

TELEPHONE (847)635-4000 FAX #: (847) 827-5796

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Page 10A

Facility Name & ID Number Lee Manor

0024356 Report Period Beginning:

1/1/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 106,300 B. General Construction Type: Exterior Brick, Dryvit Frame Fire-Proof brick Number of Stories 5C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Land</u>	<u>110,000</u>	<u>1977</u>	<u>\$ 273,400</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 273,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	272	1979	1979	\$ 4,087,968	\$	40	\$ 102,999	\$ 102,999	\$ 2,623,396
5		1979	1979	337,653		40	8,441	8,441	223,149
6	10	1985	1985	226,649	3,512	40	6,475	2,963	132,738
7									
8									
Improvement Type**									
9	Improvements	1979		6,000		N/A			
10	Improvements	1981		42,962		20			42,962
11	Audit Adjustment	1979		2,779		40	69	69	1,835
12	Audit Adjustment	1981		90,599		40	2,265	2,265	17,232
13	Improvements	1983		46,881		20			46,881
14	Audit Adjustment	1984		25,000		20	625	625	25,000
15	Improvements	1986		36,400	1,893	20	1,820	(73)	35,490
16	Improvements	1988		8,536	271	31.5	271		4,630
17	Improvements	1989		7,785		31.5	311	311	5,235
18	Improvements	1989		9,621		15			9,621
19	Improvements	1991		18,843		15	1,256	1,256	18,125
20	Improvements	1992		61,618	1,956	20	3,081	1,125	42,364
21	Improvements	1993		4,548	117	20	227	110	2,838
22	Improvements	1993		36,719		40	917	917	11,004
23	Improvements	1994		16,738		40	418	418	4,807
24	Improvements	1994		8,299	213	40		(213)	8,299
25	Improvements	1995		8,287	155	40	415	260	4,357
26	Improvements	1995		87,711	2,318	40	2,156	(162)	22,656
27	Brick work	1996		3,040	78	20	152	74	1,444
28	Roof Replacement	1996		1,465	38	20	73	35	694
29	Facia, Overhang renovation	1996		75,200		39	1,902	1,902	18,082
30	Hot Water heater	1996		16,084		39	417	417	3,959
31	Insulation	1997		38,770	892	39	994	102	8,449
32	Roofing	1997		5,875		39	150	150	1,275
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Refurbishing of hallways and patient room	1997	\$ 59,595	\$	20	\$ 2,980	\$ 2,980	\$ 25,559		37
38 Tile	1997	20,696		20	1,035	1,035	8,877		38
39 Electrical improvement:	1997	4,112		20	206	206	1,767		39
40 Plumbing Improvements:	1997	3,773		20	188	188	1,613		40
41 Basement remodeling	1998	13,578	348	20	679	331	5,092		41
42 smoke dampers	1998	2,235	57	20	112	55	840		42
43 Circulating pump	1998	2,630	67	20	132	65	990		43
44 Fire alarm system	1998	4,715	121	20	236	115	1,770		44
45 Compressor	1998	7,653	196	20	382	186	2,865		45
46 Boiler Valve	1998	3,233	83	20	162	79	1,215		46
47 Window Glazing	1998	2,566	66	20	128	62	960		47
48 Landscaping	1998	977	25	20	48	23	360		48
49 Patio Brick	1998	2,590	66	20	130	64	975		49
50 Ceiling Tiles	1998	2,233		20	112	112	1,685		50
51 Window Treatments:	1998	2,470	131	20	124	(7)	930		51
52 Sliding Doors	1999	854		20	43	43	279		52
53 Air Conditioning improvement:	1999	685		20	34	34	221		53
54 Code Alert Wandering Svsten	1999	511		20	26	26	169		54
55 Elevator upgrade	1999	50,000	1,295	20	2,500	1,205	16,250		55
56 Roof Improvements	1999	3,567		20	178	178	1,157		56
57 Hallway renovation-ceiling tile,wiring,painting , doos & til	2000	40,411	1,036	39	1,036		5,817		57
58 Elevators	2000	20,000	513	39	513		2,972		58
59 hallway renovation-Labo:	2000	9,048	232	39	232		1,305		59
60 Hallway Renovation- materials. Painting and labo	2000	7,303	187	39	187		1,038		60
61 Painting- labor	2000	2,859	73	39	73		405		61
62 Compressor	2000	20,674	530	39	530		2,717		62
63 windows	2000	91,557	2,348	39	2,348		12,034		63
64 Automatic Doors	2000	1,985	51	39	51		295		64
65 Painting - Labor	2000	11,630	298	39	298		1,602		65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 5,706,170	\$ 19,166		\$ 150,137	\$ 130,971	\$ 3,418,281		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,706,170	\$ 19,166		\$ 150,137	\$ 130,971	\$ 3,418,281	1
2	Furnace Room Improvement	2001	3,259	84	39	84		402	2
3	Third floor remodeling	2001	72,480	1,858	39	1,858		7,892	3
4	fourth floor remodeling	2001	64,481	1,653	39	1,653		6,680	4
5	water heater, wallpaper & tile	2001	19,553	501	39	501		2,443	5
6	remodeling	2001	5,768	148	39	148		685	6
7	Window Systems	2001	8,059	207	39	207		1,026	7
8	Renovation Floor 2 & 5, balance of floor 3&4	2002	340,426		39	8,729	8,729	30,922	8
9	Renovation floor 1, residual of floor 2 & 5	2002	181,976		39	4,666	4,666	14,193	9
10	Building Signs	2002	1,449		39	37	37	122	10
11	Beauty Parlor	2002	681		39	17	17	53	11
12	Alarm	2002	893		39	23	23	81	12
13	Door Enunciator	2002	1,944		39	50	50	177	13
14	2nd Floor Renovation	2003	87,417		39	2,241	2,241	4,673	14
15	Exterior Rehab - Dryvit	2003	23,197		39	595	595	1,241	15
16	Exterior Rehab - Dryvit	2003	36,728		39	942	942	1,964	16
17	Fuel Tank	2003	16,616		39	426	426	888	17
18	Alarm System	2003	35,000		39	897	897	1,871	18
19	Kitchen Repairs	2003	2,005		39	51	51	107	19
20	Parking lot repair	2003	2,155		39	55	55	115	20
21	Door Hardware	2003	1,354		39	35	35	73	21
22	Carpet for offices	2003	1,468		39	38	38	78	22
23	Landscaping	2003	6,386		39	164	164	342	23
24	Rebuild Kitchen Stairwell	2003	1,580		39	41	41	85	24
25	Grab bars	2003	1,102		39	28	28	58	25
26	water Heater & Storage Tank	2003	13,634		39	350	350	730	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,635,781	\$ 23,617		\$ 173,973	\$ 150,356	\$ 3,495,182	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,635,781	\$ 23,617		\$ 173,973	\$ 150,356	\$ 3,495,182	1
2	Landscaping	2004	11,953		15	797	797	1,018	2
3	Dialysis room	2004	3,188		27.5	116	116	173	3
4	Air handler	2004	8,529		27.5	310	310	465	4
5	Back entrance renovation	2004	4,104		27.5	149	149	224	5
6	Building face resurfacing	2004	47,218		27.5	1,717	1,717	2,576	6
7	Chimney inducer	2004	32,366		27.5	1,177	1,177	1,765	7
8	Dialysis room	2004	13,645		27.5	496	496	744	8
9	Floor renovation	2004	78,376		27.5	2,850	2,850	4,275	9
10	Tunner cleaning	2004	1,260		27.5	46	46	69	10
11	Refuse disposal	2004	5,012		27.5	182	182	273	11
12	Roofing	2004	14,500		27.5	527	527	791	12
13	Security System	2004	59,500		27.5	2,164	2,164	3,246	13
14	Water heater & storage tank	2004	20,208		27.5	735	735	1,102	14
15	Painting	2004	3,510		27.5	128	128	192	15
16	Pump	2004	4,922		27.5	179	179	268	16
17	Remodeling 2nd floor Transitional Care Uni	2005	37,276		27.5	678	678	678	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,981,348	\$ 23,617		\$ 186,224	\$ 162,607	\$ 3,513,041	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number: Lee Manor

0024356

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 414,842	\$ 41,006	\$ 41,761	\$ 755	Various	\$ 164,426	71
72	Current Year Purchases	63,701	6,371	6,371		5	6,371	72
73	Fully Depreciated Assets	765,618					765,618	73
74								74
75	TOTALS	\$ 1,244,161	\$ 47,377	\$ 48,132	\$ 755		\$ 936,415	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,498,909	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,994	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 234,356	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 163,362	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,449,456	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 11,445 Description: See Sch 14A
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning
 Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2006 \$
 13. /2007 \$
 14. /2008 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Lee Manor
Provider #: 0024356
12/31/2005

Schedule 14A

XII. Rental Costs

Line 16 Rental amount for movable equipment:

Lessor	Equipment Type	Cost
Advanced Systems	Mattresses	4,263
ADT Security Service	Security equipment	182
City Capital	Copier	7,000
		<u>11,445</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor # 0024356 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities:

\$ _____

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	L10a, C3	1760	hrs	\$ 69,477		\$	1,760	\$ 69,477	1	
2	Licensed Speech and Language Development Therapist	L10a, C3		hrs		1,969	26,996		1,969	26,996	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10a, C3	3836	hrs	120,180	95	1,046		3,931	121,226	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescripts				245,364		245,364	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Dialysis	L39, C3					40,100			40,100	13
14	TOTAL				\$ 189,657	2,064	\$ 68,142	\$ 245,364	7,660	\$ 503,163	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed
 Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed
 on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 56,322	\$ 80,564	1
2	Cash-Patient Deposits	10,495	10,495	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 317,766)	1,595,099	1,595,099	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,692	77,692	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,155,975)	337	8
9	Other(specify): Escrow - taxes		137,315	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 583,633	\$ 1,901,502	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,400	13
14	Buildings, at Historical Cost	760,288	5,459,590	14
15	Leasehold Improvements, at Historical Cost	1,039,097	1,521,758	15
16	Equipment, at Historical Cost	1,249,473	1,244,161	16
17	Accumulated Depreciation (book methods)	(1,615,511)	(4,449,456)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Equip. Deposit	13,567	13,567	22
23	Other(specify): Mortgage costs		31,801	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,446,914	\$ 4,094,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,030,547	\$ 5,996,323	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 483,367	\$ 483,367	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	376,788	376,788	28
29	Short-Term Notes Payable	1,182,671	1,182,671	29
30	Accrued Salaries Payable	119,479	119,479	30
31	Accrued Taxes Payable (excluding real estate taxes)	147,112	147,112	31
32	Accrued Real Estate Taxes(Sch.IX-B)		397,576	32
33	Accrued Interest Payable	18,443	35,126	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	82,137	89,051	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,409,997	\$ 2,831,170	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,192,152	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,192,152	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,409,997	\$ 9,023,322	46
47	TOTAL EQUITY (page 18, line 24)	\$ (379,450)	\$ (3,026,999)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,030,547	\$ 5,996,323	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Seneca Nursing Home Inc., d/b/a Lee Manor Nursing Residence

Provider # 0024356

12/31/2005

Schedule 17A

XV. Balance Sheet

C. Current Liabilities	<u>Operating</u>	<u>After Consolidation</u>
-------------------------------	-------------------------	---------------------------------------

Line 36 - Other Current Liabilities

Accrued Expenses	51,352	51,352
Due to Related Party	-	6,914
Accrued Assessment	(570)	(570)
Pension Plan	30,509	30,509
Garnishment	846	846
Total - Line 36	<u>82,137</u>	<u>89,051</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (116,543)	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	(20,501)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (137,044)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(242,406)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (242,406)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (379,450)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,671,015	1
2	Discounts and Allowances for all Levels	(3,504,789)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,166,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	688,110	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 688,110	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,026	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	208,692	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	16,069	19
20	Radiology and X-Ray		20
21	Other Medical Services	228,686	21
22	Laundry	8,322	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 464,795	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	5,932	28
28a	Vending Income	2,630	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,562	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,327,693	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,474,221	31
32	Health Care	4,246,989	32
33	General Administration	1,776,940	33
	B. Capital Expense		
34	Ownership	1,491,514	34
	C. Ancillary Expense		
35	Special Cost Centers	426,610	35
36	Provider Participation Fee	153,825	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,570,099	40
41	Income before Income Taxes (line 30 minus line 40)**	(242,406)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (242,406)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning: 1/1/2005

Ending:

12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,768	1,824	\$ 78,806	\$ 43.21	1
2	Assistant Director of Nursing	2,424	2,534	70,224	27.71	2
3	Registered Nurses	35,958	46,134	1,167,854	25.31	3
4	Licensed Practical Nurses	10,601	12,590	297,781	23.65	4
5	CNAs & Orderlies	109,604	125,086	1,289,112	10.31	5
6	CNA Trainees					6
7	Licensed Therapist	5,596	5,819	189,657	32.59	7
8	Rehab/Therapy Aides	6,846	7,705	108,739	14.11	8
9	Activity Director					9
10	Activity Assistants	13,973	15,016	126,003	8.39	10
11	Social Service Worker	6,059	6,588	76,086	11.55	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,433	43,277	343,063	7.93	15
16	Dishwashers					16
17	Maintenance Worker	3,388	3,796	42,786	11.27	17
18	Housekeepers	39,507	42,484	295,495	6.96	18
19	Laundry	7,724	8,397	58,866	7.01	19
20	Administrator	2,104	2,216	83,532	37.69	20
21	Assistant Administrator					21
22	Other Administrative	168	175	4,500	25.71	22
23	Office Manager					23
24	Clerical	21,288	23,341	396,606	16.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,204	4,757	55,974	11.77	31
32	Other Health Care(specify)					32
33	Other(specify) See Schedule 20A	7,388	9,511	255,757	26.89	33
34	TOTAL (lines 1 - 33)	319,033	361,250	\$ 4,940,841 *	\$ 13.68	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	242	\$ 11,856	L1, C3	35
36	Medical Director	Monthly	24,000	L9, C3	36
37	Medical Records Consultant	24	1,320	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	39,000	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,144	L11, C3	44
45	Social Service Consultant	53	2,625	L12, C3	45
46	Other(specify)				46
47	Religious service	Monthly	575	L12, C3	47
48					48
49	TOTAL (lines 35 - 48)	363	\$ 81,520		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Seneca Nursing Home, Inc. d/b/a Lee Manor Nursing Residence
Provider # 0024356
12/31/2005

Schedule 20A

Name	Number of Hrs. Actually Worked	# of hours Paid	Reporting period Total Sal & Wages	Average Hourly Wage
Nurse Supervisor	3998	5298	148,547	28.04
MDS Coordinator	3390	4213	107,210	25.45
Total	7,388	9,511	255,757	26.89

See Accountants' Compilation Report

A. Administrative Salaries:			Ownership		D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount		Description	Amount	Description	Amount
William McNiff	Administrator	0	\$ 42,154		Workers' Compensation Insurance	\$ 67,126	IDPH License Fee	\$ 1,990
Carol L Terrill	Administrator	0	41,378		Unemployment Compensation Insurance	58,344	Advertising: Employee Recruitment	
Chester Plodzien	Administrative	10	4,500		FICA Taxes	386,495	Health Care Worker Background Check	
					Employee Health Insurance	171,443	(Indicate # of checks performed <u>85</u>)	1,040
					Employee Meals	6,573	Illinois Council on Long-Term Care	8,892
					Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	6,200
					401(K) Contributions	30,418	Miscellaneous License and Permits	2,840
					Other employee benefits	17,055	Misc. Inspections	358
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 88,032					
B. Administrative - Other								
Description			Amount					
Management Fees			\$ 93,333				Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 93,333		TOTAL (agree to Schedule V,	\$ 737,454	TOTAL (agree to Sch. V,	\$ 21,320
(Attach a copy of any management service agreement)					line 22, col.8)		line 20, col. 8)	
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount		Description	Line #	Amount	
Richard P Sora	Legal		\$ 13,418					
Schiff Hardin & Wait	Legal		20,830					
Scott & Kraus, LLC	Legal		4,417					
Chicago Legal Clinic	Legal		1,668		N/A			
Bank One	Legal		3,400					
Dennis W. Hetler	Legal		11,492					
American Express TBS	Accounting		9,008					
Altschuler Melvoin & Glasser	Accounting		17,367					
Peterek & Howse	Accounting		6,000					
Systematic Management	Billing Consultant		13,269					
See Schedule 21A			22,054					
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 122,923			\$		

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lee Manor
Provider #: 0024356
12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
ADP	Data Processing	13,006
CityStar Group	Data Processing	190
Royal Management	Data Processing	1,030
Information Controls	Data Processing	95
Wescom Solutions	Data Processing	2,007
Unemployment Tax Consultant		1,620
Harold Wildman	Recruiting	2,606
Krakau Business	Recruiting	1,500
		<u>22,054</u>
Total (agree to Schedule V, line 19, column 3)		122,923
Out-of-period legal		(20,585)
Non-allowable collection fees		(13,418)
Reclassification to RE taxes		(11,492)
Reclassification to dues and subscriptions		(556)
Total (agree to Schedule V, line 19, column 8)		<u>76,872</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 6 7 8 9 10 11 12 13 Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lee Manor

0024356

Report Period Beginning:

1/1/2005

Ending:

12/31/2005

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount ICLTC - \$8,892
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 73,143 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/a
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 153,825
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these function
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 6,573 Has any meal income been offset against related costs? Yes Indicate the amount \$ 2,630
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT

11:23 AM 6/6/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-592,441	equal to	-592,441	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	413,246	equal to	413,246	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	442,571	equal to	442,571	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	234,356	equal to	234,356	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	11,445	equal to	11,445	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	189,657	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	256,699	equal to	256,699	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	245,364	equal to	245,364	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,474,221	equal to	1,474,221	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,246,989	equal to	4,246,989	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,776,940	equal to	1,776,940	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,491,514	equal to	1,491,514	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	426,610	equal to	426,610	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	153,825	equal to	153,825	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,324,247	equal to	3,324,247	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	189,657	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	126,003	equal to	126,003	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	76,086	equal to	76,086	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	343,063	equal to	343,063	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	42,786	equal to	42,786	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	295,495	equal to	295,495	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	58,866	equal to	58,866	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	88,032	equal to	88,032	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	396,606	equal to	396,606	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,940,841	equal to	4,940,841	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,856	< or = to	11,856	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,320	< or = to	1,320	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	2,144	< or = to	2,144	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,625	< or = to	3,200	-575	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	88,032	equal to	88,032	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	93,333	equal to	93,333	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	122,923	equal to	122,923	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	737,454	equal to	737,454	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	21,320	equal to	21,320	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,273	equal to	6,273	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	153,825	equal to	153,825	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	6,573	< or = to	6,573	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	6,573	equal to	6,573	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,597	equal to	6,597	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-353,234	equal to	-353,234	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	7,374,823	equal to	7,374,823	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	397,576	equal to	397,576	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	273,400	equal to	273,400	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,981,348	equal to	6,981,348	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,244,161	equal to	1,244,161	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,449,456	equal to	4,449,456	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-379,450	equal to	-379,450	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-242,406	equal to	-242,406	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,030,547	equal to	2,030,547	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	343,063	43,035	11,856	397,954	0	397,954	0	397,954
2. Food Purchase	0	320,166	0	320,166	0	320,166	-9,203	310,963
3. Housekeeping	295,495	30,066	0	325,561	0	325,561	0	325,561
4. Laundry	58,866	21,601	0	80,467	0	80,467	-8,322	72,145
5. Heat and Other Utilities	0	0	209,889	209,889	0	209,889	0	209,889
6. Maintenance	42,786	6,974	90,424	140,184	0	140,184	0	140,184
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	740,210	421,842	312,169	1,474,221	0	1,474,221	-17,525	1,456,696
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	3,324,247	408,609	1,320	3,734,176	0	3,734,176	0	3,734,176
10a. Therapy	189,657	0	67,042	256,699	0	256,699	0	256,699
11. Activities	126,003	24,681	2,144	152,828	0	152,828	0	152,828
12. Social Services	76,086	0	3,200	79,286	0	79,286	0	79,286
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,715,993	433,290	97,706	4,246,989	0	4,246,989	0	4,246,989
17. Administrative	88,032	0	93,333	181,365	0	181,365	0	181,365
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	122,923	122,923	0	122,923	-46,051	76,872
20. Fees, Subscriptions & Promotion	0	0	21,349	21,349	0	21,349	-29	21,320
21. Clerical & General Office	396,606	48,388	51,700	496,694	0	496,694	-5,152	491,542
22. Employee Benefits & Payroll	0	0	730,881	730,881	0	730,881	6,573	737,454
23. Inservice Training & Education	0	0	17,487	17,487	0	17,487	0	17,487
24. Travel and Seminar	0	0	6,273	6,273	0	6,273	0	6,273
25. Other Admin. Staff Trans	0	0	7,554	7,554	0	7,554	0	7,554
26. Insurance-Prop.Liab.Malpractice	0	0	192,414	192,414	0	192,414	0	192,414
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	484,638	48,388	1,243,914	1,776,940	0	1,776,940	-44,659	1,732,281
29. Total General Administrative	4,940,841	903,520	1,653,789	7,498,150	0	7,498,150	-62,184	7,435,966
30. Depreciation	0	0	70,994	70,994	0	70,994	163,362	234,356
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	62,195	62,195	0	62,195	351,051	413,246
33. Real Estate	0	0	3,000	3,000	0	3,000	439,571	442,571
34. Rent - Facility & Grounds	0	0	1,343,880	1,343,880	0	1,343,880	-1,343,880	0
35. Rent - Equipment & Vehicles	0	0	11,445	11,445	0	11,445	0	11,445
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,491,514	1,491,514	0	1,491,514	-389,896	1,101,618
38. Medically Necessary T	0	0	785	785	0	785	0	785
39. Ancillary Service Cent	0	245,364	40,100	285,464	0	285,464	0	285,464
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	153,825	153,825	0	153,825	0	153,825
43. Other (specify):*	0	0	140,361	140,361	0	140,361	-140,361	0
44. Total Special Cost Ce	0	245,364	335,071	580,435	0	580,435	-140,361	440,074
45. Grand Total	4,940,841	1,148,884	3,480,374	9,570,099	0	9,570,099	-592,441	8,977,658

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	56,322	80,564
2. Cash - Patient Deposits	10,495	10,495
3. Accounts & Notes Receivable	-1,595,099	-1,595,099
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	77,692	77,692
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	-1,155,975	337
9. Other (specify):	0	137,315
10. Total current assets	-2,606,565	-1,288,696
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	273,400
14. Buildings, at Historical Cost	760,288	5,459,590
15. Leasehold Improvements, Historical Cost	1,039,097	1,521,758
16. Equipment, at Historical Cost	1,249,473	1,244,161
17. Accumulated Depreciation (book methods)	-1,615,511	-4,449,456
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	13,567	13,567
23. other (specify):	0	31,801
24. Total Long-Term Assets	1,446,914	4,094,821
25. Total Assets	-1,159,651	2,806,125
CURRENT LIABILITIES		
26. Accounts Payable	483,367	483,367
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	376,788	376,788
29. Short-Term Notes Payable	1,182,671	1,182,671
30. Accrued Salaries Payable	119,479	119,479
31. Accrued Taxes Payable	147,112	147,112
32. Accrued Real Estate Taxes	0	397,576
33. Accrued Interest Payable	18,443	35,126
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	82,137	89,051
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,409,997	2,831,170
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	6,192,152
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	6,192,152
46. Total Liabilities	2,409,997	9,023,322
47. Total Equity	-379,450	-6,217,197
48. Total Liabilities and Equity	2,030,547	2,806,125

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	11,671,015
2. Discounts and Allowances for all Levels	-3,504,789
Subtotal - Inpatient Care	8,166,226
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	688,110
7. Oxygen	0
Subtotal - Ancillary Revenue	688,110
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,026
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	208,692
18. Sale of Supplies to Non-Patients	0
19. Laboratory	16,069
20. Radiology and X-Ray	0
21. Other Medical Services	228,686
22. Laundry	8,322
Subtotal - Other Operating Revenue	464,795
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	8,562
Subtotal - Other Revenue	8,562
30. Total Revenue	9,327,693
31. General Services	1,474,221
32. Health Care	4,246,989
33. General Administration	1,776,940
34. Ownership	1,491,514
35. Special Cost Centers	426,610
35. Provider Participation Fee	153,825
37. Other	0
40. Total Expenses	9,570,099
41. Income Before Income Taxes	-242,406
42. Income Taxes	0
43. Net Income or Loss for the Year	-242,406